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TUFTS Health Plan

February 6, 2009

Leslie Kirwan, Co-Chair, Special Commission on the Health Care Payment System
Secretary, Executive Office for Administration and Finance
State House, Room 373
Boston, MA 02108

Sarah Iselin, Co-Chair, Special Commission on the Health Care Payment System
Commissioner, Division of Health Care Finance and Policy
2 Boylston Street, 5th Floor
Boston, MA 02116

Re: Tufts Health Plan's Testimony before the Commission on the Health Care Payment System

Dear Secretary Kirwan and Commissioner Iselin:

Thank you for the opportunity to provide testimony. My name is Marc Spooner. I am the Vice President of Provider Contracting for Tufts Health Plan. Tufts Health Plan provides insurance coverage for roughly 720,000 members. Since 1979, Tufts Health Plan has been committed to providing a higher standard of health care coverage and to improving the quality of care for every member. Tufts Health Plan's Health Maintenance Organization (HMO) and Point of Service (POS) plans are ranked second by *U.S. News & World Report*/National Committee for Quality Assurance (NCQA) and its Medicare Advantage plan, Tufts Health Plan Medicare Preferred, is ranked number ten in the nation.

One of the important topics that the Special Commission is evaluating is the use of differing reimbursement models between payers and providers. At Tufts Health Plan, we utilize a variety of models - - including capitation, pay-for-performance (P4P) and fee-for-service reimbursement. The use of these models depends heavily on the type of business for which we are contracting (fully insured commercial, self-insured commercial business or Medicare) as well as the type of provider, their ability to invest in infrastructure to manage care and their scope of services. The purpose of this testimony is to provide a more detailed look at our Medicare Preferred Contracting approach, the nature of the risk-based contracts we employ, and the way in which these contracts align incentives for payers and providers so that quality and cost are appropriately managed.

Background Information

- Tufts Health Plan serves roughly 74,000 Medicare HMO members
- Approximately 93% of these members are managed by providers who have a risk-based contract with Tufts Health Plan
- Some of these same providers employ a risk-based contract with Tufts Health Plan for a portion of their Commercial population

What does it mean for a Tufts Health Plan Medicare Provider to be "At Risk"

- A risk-based contract implies that providers, and more specifically PCP providers, have an annual medical budget defined by the total expected costs for caring for their patient population
    - If the cost of their members' care is less than this budget, these providers earn a financial "surplus"
    - If the cost of their members' care is greater than this budget, providers are in financial "deficit"
- To varying degrees, PCP groups share financial risk (both upside "surpluses" and downside "deficits") with other business partners including: physician specialists, their affiliated hospital, and Tufts Health Plan
- Shared risk arrangements provide strong incentives for plans and providers to work together to manage care and costs; this same potential for higher PCP payments and alignment of incentives does not exist under traditional FFS Medicare

How does Tufts Health Plan Control for the Quality of Care in this Model?

- Tufts Health Plan routinely monitors under use and overuse of services and works extensively with providers to monitor the quality of care being delivered
- A recent study by MHQP evaluating the quality of care delivered to Massachusetts Medicare Advantage members (of which THP has approximately 41% market share) concluded that on the six quality of care measures studied, the care delivered by Medicare Advantage plans exceeded that delivered by FFS Medicare by 10% to 20%
- Tufts Health Plan also deploys a number of disease management programs in partnership with physicians to manage care for complex medical cases as well as chronic conditions like Chronic Obstructive Pulmonary Disorder (COPD) and Congestive Heart Failure (CHF)

Why are Providers Willing to be "At Risk?"

- **Provider Infrastructure**
    - Providers who accept risk have developed processes to effectively manage how members receive their medical care. By way of example, they often utilize nurse practitioners to extend their presence at skilled nursing facilities or other non-acute settings. They have referral relationships in place to allow for appropriate specialty and hospital care. They have mechanisms to manage required follow-up care

- **The Potential for Higher Payments not Available under FFS Medicare**
  - Providers who make the appropriate investment of time and effort in managing the care of their patients have the opportunity to earn more than they do under FFS Medicare

- **Provider Ability to Manage**
  - Providers who accept risk have made a concerted choice to play an active role in working with members to direct their medical care. This does not come without effort. THP has found that medical groups willing to play this role can do so successfully with high levels of patient satisfaction

- **Tufts Health Plan Support**
  - Tufts Health Plan has a unit that assists provider groups as they deliver medical care. This support is led by a THP physician and Clinical Services personnel who share best practices among groups, provide regular reporting and help to identify group-specific trends which affect provider performance

Can Tufts Health Plan's Medicare Experience be Transferred to a Commercial Population?

- As noted above, some providers who are "at risk" for Tufts Health Plan Medicare members are also at risk for a portion of their Tufts Health Plan Commercial membership
- For some providers, this is a matter of philosophy: they deploy their care delivery model across their entire set of patients regardless of payer type; if they are comfortable directing medical care for a Medicare population, they are comfortable doing the same for a Commercial population
- Other providers view the Medicare population as more willing to be directed by their PCP than an average Commercial member who has become accustomed to seeing the specialist of their choosing
- Tufts Health Plan believes that three factors will ultimately drive providers to accept financial risk for a portion of their Commercial population:
  - **Infrastructure**: do providers have the capital and/or experience to develop the processes to appropriately direct referral patterns and manage members' medical care?
  - **Scope of Services**: do providers have sufficient breadth of services so that they can manage the full continuum of care within their organization?
  - **Degree of Physician / Hospital integration**: do providers have sufficient integration across various places of service to appropriately coordinate care in multiple settings?

While Tufts Health Plan has a range of reimbursement methods, we have found that risk-sharing mechanisms best align incentives with the provider community. In so doing, the model creates the potential to appropriately manage scare medical resources without compromising the high quality of care that members deserve. Despite its benefits, risk-sharing requires a degree of provider infrastructure and organization that is not easily built. Based on the historical and continuing experience of Tufts Health Plan, we regard risk-sharing contracts not as a panacea for cost management, but rather as a key option to be considered when developing a contract relationship with our network of providers.

We appreciate the opportunity to offer our comments. If we can be of assistance in responding to additional questions, please contact me at 617-972-1054.

Sincerely,

Marc Spooner
Vice President, Provider Contracting
Tufts Health Plan